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ABSTRACT

Because the use of clinical supervision methods by administrators in their evaluation and supervision of teachers has been linked to instructional improvement, administrators' perceptions about the implementation of clinical supervisory practices were surveyed. Participants in the study were 412 school district administrators and supervisors who had received training in clinical supervision; some of the participants, administrators and supervisors from Greensboro, North Carolina, had received more training than their peers and had implemented a plan for central office management of clinical supervision. Attitudinal and procedural differences between the Greensboro administrators and the other administrators were apparent in the survey results. Greensboro administrators used the preconference stage of clinical supervision more appropriately than did other respondents, practiced more conference followup, and used more effective instruction models. In studying differences in the implementation of clinical supervision, it was found that motivation to help teachers dominates administrative and supervisory practices. Administrators and supervisors tended to view clinical supervision as a coaching, rather than as an evaluation, technology. The stages of clinical supervision were practiced by most respondents, with the exception of the preconference contract stage. Collected data formed the basis for observation analysis and guided the teacher feedback sessions. The training helped to alter supervision techniques, but, when the training was accompanied by strong district central office involvement, greater skill development and institutionalization resulted. (FG)

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THE IMPLEMENTATION OF CLINICAL SUPERVISION

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The Implementation of Clincical Supervision

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In the past five years there has emerged a widespread interest in clinical supervision. In attempts to improve the norms of student achievement, school administrators have come to perceive that within clinical supervision there exists an unusually effective mechanism for improving the quality of instruction. At the same time, researchers have uncovered certain instructional variables which positively influence student achievement, and have observed that clinical supervision can and should focus on these variables. Thus, clinical supervision has been linked to a number of instruction models and has become a coaching mechanism for improving instruction.

Often conflicting for administrators, however, are the policy requirements of district evaluation systems. The time available to administrators is sometimes totally absorbed by attending to the required number of evaluation-observations and other administrative tasks. Consequently, clinical supervision methodologies are often neglected because of involvement in evaluation, and the task of coaching remains unfinished.

Having conducted clinical supervision training in a number of school districts across the country and observed the difficulties that so many administrators have experienced in implementing clinical supervision, we became curious about both the adult learning process and the district organizational factors that appear to facilitate or hinder clinical supervision implementation.

Joyce reported from his studies on skill/concept implementation in California, that on-the-job coaching and assistance is necessary for widespread implementation of a practice introduced in a workshop. Our own informal observations have confirmed this finding: unless principals and supervisors are engaged in a planned follow-up of clinical supervision workshops, clinical supervision as a complete technology is unlikely to be practiced. Thus we decided to question those who had been

trained by us to learn what factors helped or hindered clinical supervision implementation, and to uncover cognitive, affective and behavioral manifestations of clinical supervision implementation.

PURPOSE

The purpose of this paper is to report several of our findings, and to share reactions, possible implications and new questions. Since the study was limited to those school district administrators and supervisors trained by us, it seems important to present what we perceive to be the indicators of clinical supervision implementation (Goldhammer, 1980; Anderson,1980). The study was designed to uncover the following manifestations:

1. The complete combination of pre-observation contracting, in-class observation, data collection, data analysis and conferencing activities is practiced in each clinical supervision cycle.
2. Classroom observation is preceded by a plan for teacher skill development.
3. Clinical supervision is used as a coaching, rather than an evaluation, technology.
4. Clinical supervision emerges from a growth inducing relationship between supervisor and teacher, with the intent of the supervisor being to intervene in some helpful way in the teacher's instructional practices.
5. Systematic and intensive data collection occurs with each observation.
6. The focus of each observation emerges from a combination of factors:
    - the teacher's annual goals
    - the teacher's lesson objectives
    - the supervisor's perception of deficiency needs
    - the teacher's concerns
    - a jointly-held theoretical/conceptual model of effective instruction

7. At the end of each clinical cycle the teacher is able to understand what worked and did not work in the lesson observed, as evidenced by collected data, and to define next steps in an improvement process.

STUDY DESIGN

Twelve school districts were selected for the study, with a total of 412 participants (see Table 1). All respondents had received between one to four days of training in clinical supervision, except for Greensboro (North Carolina) principals and teachers who had ten or more training sessions. Those administrators, supervisors (and in some cases, teachers) who received clinical supervision training were asked to complete and return a questionnaire describing their supervision practices following training. Thus, personal perceptions about practice formed the data base for our study.

Items on the questionnnaire were developed to elicit reports of clinical supervision implementation in the following categories:

Types of Supervision Practice
Planning for Supervision
Purposes for Observation
Pre-observation Conference Patterns
Observation Techniques
Data Analysis
Post Observation Conference Patterns
Framework for Instructional Improvement
Supervisory Performance Critique
Central Office Role

Several statistical procedures were used to analyze the data, only three of which are reported here.

In order to establish patterns of clinical supervision practice following training among all participants, a mean was calculated for responses to each item. A standard deviation was then calculated to determine relative degrees of clustering around the mean. In addition, since several questions require either multiple choice or open ended responses, those responses were tallied to

TABLE 1

SCHOOL DISTRICTS TRAINED AND SURVEYED

School District	Trainee's
1. Bozeman, MT	Central Office/Principals
2. Northside ISD; San Antonio, TX	Principals/Teachers
3. Princeton, N.J.	Principals/Teachers
4. Greensboro, N.C.	Principals/Teachers
5. Ritenour, MO	Central Office/Principals
6. South Brunswick, N.J.	Central Office/Principals
7. Hampton, VA	Central Office/Principals
8. Dickinson, TX	Central Office/Principals
9. Penn Harris, Madison, IN	Central Office/Principals
10. Coahoma, TX	Central Office/Principals
11. Dallas, TX East Oak Cliff Subdistrict	Central Office/Principals
12. Copperas Cove, TX	Central Office/Principals

obtain additional kinds of information regarding practice.

Since Greensboro participants had additional days of training and there was a plan for central office management of clinical supervision implementation, we were eager to learn what differences these two practices played in actual clinical supervision implementation. A "T" test was run on the two groups (Greensboro-all other districts) in order to determine a T value and its significance for each item.

All test results were then studied to tease out manifestations of clinical supervision implementation and school district factors that aided in the implementation. A survey report of several studies is discussed below.

The instrument developed for this study has a Cronbach Alpha reliability coefficient of 0.80433, which is adequate for our research purpose.

RESULTS

Agreement Among All Roles

We were eager to learn how persons occupying all roles perceived clinical supervision concepts and practiced clinical supervision methods after training. As a result of calculating a mean and standard deviation on each question, various patterns emerged. The responses were divided into three groups: 1) those items which elicited strong agreement (S=.0850-1.0), 2) those items which generated only mild agreement (S=1.1-1.25), and 3) those items which produced disagreement (S=1.25-1.35).

In Table 2, note that all role occupiers trained in clinical supervision agree strongly that clinical supervision is a technology for helping teachers. Data reported later, however, suggest that clinical supervision may be equated with evaluation in the minds of some and therefore the myth that "evaluation helps" may influence responses to this question. Respondents also agree that clinical supervision grows out of a school plan to improve instruction. Further study is needed to determine whether such school plans are informal or formal,

and whether they are only in the minds of administrators or are known and shared among the entire staff.

One additional practice seems worth noting. A data base for analyzing and planning for instructional improvement seems to be an important element to most respondents in practicing clinical supervision. The "eyes-only" approach to observation seems to have given way to systematic and detailed data collection during observation for those surveyed. Further study is necessary to determine the nature of actual data collection practices.

Table 2 here

One intriguing finding was the strong positive response made by administrators to self criticism following a clinical supervision cycle. One response mean suggests that some criticism is practiced ($\bar{X}$=3.944), although the response mean to another question suggests that using recording devices to do such rarely occurs ($\bar{X}$=1.862). That self examination exists to some extent among administrators, seems to be a positive indicator that the quality of coaching teachers through clinical supervision increases the chances of changing the behavior of teachers.

Table 3 illustrates the areas in which there is only mild agreement among respondents. All roles generally agreed that clinical supervision is a methodology for coaching purposes ($\bar{X}$ = 3.610) and conversly, that clinical supervision should not be used for evaluation purposes ($\bar{X}$ = 2.297). However, as we shall report later, a mild clustering around the mid range of responses raises questions about what is meant by such responses. An additional finding worth noting is that teachers generally tend to have opportunity for input into decisions about the focus of an observation cycle, their lesson objectives playing an important factor in determining that focus.

Table 3 here

TABLE 2

STATISTICAL OVERVIEW OF RESPONSES FOR ALL RESPONDENTS

S= .0858 - 1.0 Strong Agreement

(n=412) Scale: 1=disagree; 5=agree

Question	N	Mean	Standard Deviation
CS is to help teachers become more effective	406	4.436	0.858
CS is part of a plan for improving instruction	402	4.169	1.067
Teachers know what observer behaviors to expect	405	4.131	0.972
Agreement is reached on potential usefullness of data	403	4.114	1.057
Teachers & observers discuss data	404	4.079	0.950
Teachers have a data base for knowing what worked and what did not work	402	4.010	0.942
Teachers know how decisions are made for data collection	403	3.958	1.084
Principals & COA critique their CS behavior after each ob	124	3.944	0.998
The observer preplans behavior	395	3.684	1.087
CS help teachers become more effective	400	3.925	1.033
Conference outcomes include plans for future instruction	401	2.150	1.019
Principals & COA use recordings of conferences to critique their behavior	123	1.862	0.881

CS = Clinical Supervision
COA = Central Office Administrators
Ob = Observation

TABLE 3: STATISTICAL OVERVIEW OF RESPONSES FOR ALL RESPONDENTS

S = 1.1 - 1.25 Mild Agreement

(N=412) Scale: 1=disagree; 5=agree

Question	N	Mean	Standard Deviation
Agreement reached about specifics of observation	403	4.102	1.103
Teachers have input into decisions about ob focus	408	3.855	1.209
CS is for coaching teachers	392	3.610	1.116
We teach according to a specific model of instruction	399	3.559	1.150
Focus for observation is the teacher objectives	400	3.502	1.193
Obs are conducted when administrators perceive a need	401	2.833	1.233
Standards for defining good instruction is determined by the administrators	401	2.554	1.195
CS is for evaluating teacher	404	2.297	1.206
Observers report the good & bad without showing data	404	2.292	1.155

CS = Clinical Supervision

Ob = Observation

With respect to the framework for guiding instructional improvement efforts, responses (items four and seven on Table 3) suggest that no standard model or definition of instruction yet exists to guide clinical supervision. Given the amount of knowledge that has been produced in the last several decades by researchers, the response shown here suggests that knowledge about effective instruction is either not yet generally used, or exists only in fragmented forms in the minds of administrators and teachers.

Disagreement among roles (see Table 4) occured largely with questions about the function of Central Office Administrators (COA) in facilitating the implementation of clinical supervision. Because the number of responses to these questions was low, the disagreement may describe only the difference in perception among Greensboro respondents, or merely a weak total participant response. The lack of response to these questions suggests, however, that little COA involvement exists for clinical supervision implementation, and decisions about clinical supervision are made at individual schools.

Behavioral Patterns Across all Roles

In order to obtain more specific information about actual practice, several questionnaire items requested either multiple choice or open-ended responses. Several findings seem noteworthy. Only majority responses (rather than total) are shown in Table 5.

Classroom observation is conducted by the principal in most cases, with a great number of responses indicating that teachers also participate in observation. Teacher involvement is relatively new for many principals in teacher observation, and promises to add exponentially to the results of clinical supervision efforts.

Observation occurred in at least half of the schools surveyed between one and three times a year. This particular finding seems noteworthy. Since most school districts now require a certain number of observations for evaluation purposes, the reader is left wondering whether clinical supervision methods have actually replaced established evaluation procedures for those trained

TABLE 4: STATISTICAL OVERVIEW OF RESPONSES FOR ALL RESPONDENTS

S = 1.25 - 1.35 Disagreement

(N=412) Scale: 1=disagree; 5=agree

Question	N	Mean	Standard Deviation
Principals are aware of COA goals for CS	39	3.590	1.208
COA monitors CS progress in schools	39	3.538	1.335
COA schedules principal discussion regarding CS	40	3.525	1.358
Classroom observations are conducted in five stages	390	3.315	1.313
CS is used for the teaching staff only	42	2.952	1.306

COA = Central Office Administrators

CS = Clinical Supervision

TABLE 5

DETAILED RESPONSES FOR ALL RESPONDENTS

Total N=412 participants

Question	N	Response
Classroom observation are conducted by:	151	administrator and teacher teams
	79	administrators only
	36	central office personnel and principal
	23	a combination of persons
	123	other combination responses
Data gathered during the observation is analyzed within the framework of:	148	teacher's lesson objectives
	99	a combination of lesson objectives, school goals, and a formal teaching model
	75	teacher's lesson objectives, and school goals
	90	other combination responses
During the observation, data are collected by:	142	handwritten notes
	89	hand notes, check lists, graphs and tallies
	61	hand notes and check lists
	120	other combination responses
Teacher observation occurs:	215	between 1 and 3 times per year
	62	according to an undeterminable pattern
	56	between 3 and five times per year
	79	other combination responses
The foci of teacher-administrator dialogue about CS is:	372	missing response
	17	no response
	23	other combination responses
Briefly describe the steps you take in critiquing your performance during the observation cycle	50	"no response"
	19	review behavior, response, analyze data
	343	no response given

TABLE 5

DETAILED RESPONSES FOR ALL RESPONDENTS (cont.)

Question	N	Response
Central office personnel participate in clinical supervision in my school through:	128	no response
	125	none except on call
	31	support
	33	observe, set deadlines, set policy, keep up with goals, conduct workshops
	95	other combination responses
Role of COA in monitoring good instruction through CS:	372	missing responses
	18	no response
	22	other combination responses
Clinical Supervision is used with other than teachers in the following ways:	373	missing response
	27	no response
	12	other combination responses

in clinical supervision. Other data suggest that the purpose for observation has shifted from judging to helping, for those who were trained in clinical supervision. However, since evaluation observations must occur, it can be assumed that teachers in most cases do not receive coaching in addition to evaluation, but rather helping attitudes have replaced judging attitudes. One wonders, however, whether schools will eventually develop the capacity to provide both clinical supervision (coaching) and evaluation (judgment) for teachers.

A combination of factors seems to determine the focus for an observation: lesson objectives, school goals and a teaching model. This practice seems to be a shift from the "eyes-only" and "no instructional standards" practices that were addressed at length in each training session. Data collection is now practiced by most who received training (n=?22). Data are gathered by employing a combination of hand recording patterns. What is not clear from this study, however, is the systematic nature and reliability of those practices.

Questions about Central Office Administrator/Supervisor involvement yielded little response, not occuring for most respondents. For a few, COA tended either generally to suppport building level activity or in some cases (perhaps Greensboro) set a structure for guiding the implementation of clinical supervision.

Additional Training Coupled with Central Office Assistance

One of the questions which prompted this study was whether or not the combined effect of many days of training and an active Central Office role in clinical supervision implementation made a significant difference in actual practice. When comparing Greensboro responses to all other responses we noted several differences (see Table 6). For example, clinical supervision is used as a coaching methodology in Greensboro, whereas in other districts clinical supervision is used mostly for evaluation purposes. In addition, in Greensboro, general agreement is

TABLE 6

GREENSBORO SCORES VERSUS OTHER DISTRICT SCORES

Degrees of Significance of Difference

Sig. of T	Question
.030	Classroom observation is practiced for evaluating teachers in non Greensboro schools
.021	Prior to observation teachers and observers agree that data to be collected will be useful to teachers (Greensboro)
.014	Prior to observation, teacher & observers agree on specifics to be observed
.019	Specific model for good instruction is used
.009	Teachers are provided with a data base for learning what worked or did not during and observation
.000	Principals and COA frequently record their post observation conference to use in analyzing their performance
.000	Principals and COA critique their own professional behavior after an observation cycle
.000	The CS process is used with other roles in addition to teachers
.001	Central Office schedules principals to meet periodically to discuss the clinical supervision process and their progress
.001	Central Office monitors the use of clinical supervision in each school
.000	Principals are aware of the clinical supervision goals of the COA

reached in the preconference about the focus of observation, the data to be collected and the perceived usefullness of those data. Furthermore, a model for good instruction guides the direction of instructional improvement through clinical supervision. The significance of Greensboro's more complete clinical supervison model implementation than other districts, we hypothesize, is due to the combined effect of the number of days of training (10 over a two year period; 1-4 days elsewhere), a strong central office expectation, and a plan for assistance in implementation.

The function of Greensboro's central office is different from other districts in that the school district has goals for clinical supervision implementation, and regularly manages efforts to attain those such goals. For example, COAs schedule periodic discussions among principals about clinical supervision implementation; they monitor plans and practice events. In addition, COAs and principals critique their behavior in actual observation cycles. Further, that clinical supervision is used with other-than-teacher roles suggests that clinical supervision may be used among administrators for peer growth.

From this sub-study, we can generalize that central office played a helpful assistance function in the implementation of clinical supervision. Assistance grew out of a goal and a commitment to implement clinical supervision as a teacher coaching system. The increased number of training days in Greensboro also grew out of the same goal and facilitated skill development. The actual significance of these two variables over other districts (number of training sessions and COA assistance) is limited however, to practices in the pre conference (an agreement is reached prior to observation), the function of data (data are collected, analyzed, communicated and guide planning), and the use of a standard of instruction to guide supervision practices.

Further study would perhaps reveal more information about the actual skill levels in clinical supervision methodology between districts where building administrators were themselves coached in clinical supervision, as in Greensboro, and where there was no planned coaching.

SUMMARY

Several themes have surfaced from the sub studies reported above. In general, the data suggest that elements of clinical supervision are now being practiced by most respondents. The theme of "helping teachers" motivates clinical supervision activities for most, replacing the judgment emphasis which has dominated teacher observation efforts in the past. However, principals appear not to conduct additional observations to those expected for evaluation. Rather, they seem to have adopted a new clinical supervision mindset in evaluating teachers.

We began this study with two basic questions: "Are those who were trained in clinical supervision now implementing its methodologies, and if so, which ones?" and "Does the central office management of clinical supervision implementation efforts influence implementative results?" We shall summarize by responding to each indicator of clinical supervision implementation that was set forth in the introduction.

Manifestations of Clinical Supervision Implementation

1. A combination of pre observation contracting, in-class observation, data collection, data analysis and conferencing activities is practiced in each clinical supervision cycle.

   We cannot conclude that the basic clinical supervision activities are practiced by all respondents. However, we can report that disagreement exists about the number of stages or activities used in observation cycles ($\bar{X}$ = 3.315; S = 1.313). All respondents agreed, however, that data collected are intended to be useful in conferences, which suggests that data are collected, analyzed and used in feedback conferences. Greensboro, however, was different in that agreements about the focus for observation and the data to be collected are made in the preconference between teacher and observer(s).

2. Classroom observation is preceded by a plan for teacher skill development.

All respondents agree that clinical supervision practice grows out of a school plan to improve instruction, ($\bar{X}$ = 4.169; S = 1.067) suggesting that instructional improvement precedes according to a plan; clinical supervision is viewed as a mechanism for achieving the goals of such improvement plans. Greensboro, in addition, uses specific models of instruction to guide planned efforts in clinical supervision (t = 0.019).

3. Clinical Supervision is used as a coaching, rather than an evaluation, technology.

All respondents agree strongly, that clinical supervision is designed for helping teachers ($\bar{X}$ = 4.436; S = .0858). However, other data suggest that Greensboro uses clinical supervision to help while coaching teachers toward improvement. All other respondents use clinical supervision to help by improving the evaluation process (t value is -2.17448 at a significance level of 0.030). It may be that evaluation still remains the dominant teacher control practice for many educators, clinical supervision providing a method for improving that process. It is our judgment that when coaching practices are added to (not used instead of) evaluation practices, supervisors will contribute to more measurable growth in teachers.

4. Clinical supervision emerges from a growth relationship between supervisor and teacher with an intent to intervene in some way into instructional practice.

We are able to report that all respondents practice clinical supervision in order to help teachers improve instruction, suggesting that a growth relationship exists. Greensboro does so through a coaching approach while others help through an evaluation frame of reference. However, we are unable to determine from this study whether teacher behaviors are actually altered because of clinical supervision. We can only report that administrator intent is to help through clinical supervision.

5. Data collection occurs with each observation.

Data collection, a relatively new practice for most administrators when observing teachers, appears to be important to most respondents in this study. For example, participants strongly agree that teachers know how decisions are made for data collection ($\bar{X}$ = 3.9580; S = 1.084). However, respondents strongly agree that plans for individual instructional improvement do not grow out of conferences ($\bar{X}$ = 2.150; S = 1.019). This particular finding suggests that participants are not yet realizing the incremental growth patterns that a "next step" approach to conferencing could generate. It would appear that each observation cycle is viewed as an isolated event for most, whereas connected plans for teacher development are likely to produce more noticeable results from clinical supervision.

6. The focus of observation emerges from a combination of factors:

- teacher annual goals
- teacher lesson objectives
- supervisor perception of deficiency needs
- teacher concerns
- theoretical/conceptual model of effective instruction

Most respondents generally agree that the focus for an observation cycle is determined largely by the teacher's lesson objectives ($\bar{X}$ = 3.502; S = 1.193). For some, school goals and/or a formal teaching model also guide decisions about the observation focus (N=174). While goals, objectives and definitions of effective instruction may guide decision-making about the focus of a particular observation, other data suggest that these do not guide general school-wide efforts to improve instruction through clinical supervision.

7. At the end of each clinical cycle the teacher is able to report what worked and did not work in the lesson observed, as evidenced by collected data, and to define next steps in an improvement process.

When analyzing the responses of all participants, we find most provide teachers with a data base for discussion ($\bar{X}$ = 4.010 and S = 0.942; $\bar{X}$ = 4.079 and S = 0.950). We assume, therefore, that actual data form the basis for analyzing and observation for most respondents.

CONCLUSIONS

What can we conclude about current clinical supervision practices among these educators who have received our training? Motivation to help teachers dominates practices. Clinical supervision tends to replace evaluation procedures rather than supplying teachers with additional coaching sessions. The stages of clinical supervision are practiced by most, except for the preconference contract session. Collected data form the basis for observation analysis and guide the teacher feedback session. The absence of a preconference agreement and a conference follow-up plan, however, suggest the need to add such practices, since these are likely to improve the results of clinical supervision.

Does planned management by central office administrators, combined with more days of training, alter the patterns and the degree of clinical supervision implementation? When comparing Greensboro with other districts we find that Greensboro central office administrators play a more active assistance role. For example, Greensboro principals are aware of COA goals for clinical (P=.000); principals and COAs schedule discussions about clinical supervision progress (P=.001); principals critique their own clinical supervision performance (P=.000) and COA monitors clinical supervision progress and activities (P=.001).

When analyzing actual clinical supervision practice it appears that Greensboro implements the preconference more appropriately, uses more effective instruction models to guide the coaching function, and Greensboro practices more conference follow-up.

Are these differences worth the degree of central office involvement in intervention since much of the clinical supervision

model is practiced by those who received training? Current knowledge about adult learning and about the implementation of innovations suggests to us that in years to come, Greensboro teachers will have refined their skills to greater degrees than others because their supervisors are better able to coach them in the process. Furthermore, Greensboro schools are more likely to continue practicing clinical supervision in years to come because of the serious-minded approach COA has adopted for district-wide implementation of clinical supervision. At the least, we can say that training helps to alter some practices (in this case, the supervision of teachers), but when training is accompanied by strong central office involvement, there will be greater skill development and institutionalization of clinical supervision.

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